

INSURANCE CONSENT

I, _____, give consent to this practice to release my medical records (self, patient, or guardian) above specified to _____
(Insurance Company Name)

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request for the purpose of healthcare operations (including but not limited to, provider review function, claims payments and quality assessment). I also understand that I may revoke this consent by written request at any time with this doctor. If revoked it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

Signature: _____ Date: _____

NO SHOW/CANCELLATION POLICY

It is important to be present for your appointment. Not making your appointment inconveniences other patients. Please call us at least 24 hours in advance if you need to move your appointment time or date in order to avoid a \$25 cancellation fee. We understand that emergencies do happen therefore we allow patients the following before we decide to no longer provide services: If a patient does not show up for their appointment for 3 consecutive visits or cancel the same day of the appointment up to 3 times.

FINANCIAL POLICY

Thank you for choosing our practice! Our office staff is very committed to successfully treating and caring for your medical needs. However, it is very important to us that you understand payment of your bill is part of this treatment and care. We ask that you carefully read and initial all of the following numbered items.

1. _____. If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all services rendered. You will be responsible at the time of service for the payment of:

- **The annual deductible**
- **Co-payments**
- **Charges for non covered services**

Before services are rendered, our office will call your insurance company to verify eligibility and benefits. However, verification of benefits is **NOT** a guarantee of payment. You will be billed if:

- **We obtain a denial from your insurance company**
- **We have not received payment from the insurance company within 60 days of our filing your claim.**

We will make every effort to contact your insurance to verify benefits, but in the event we are unable to reach them, you will be responsible for your co-payment as well as payment for any procedures performed. Such procedures include but are not limited to, punctual closures, glaucoma scans, visual fields or other medically necessary testing.

2. _____. If you purchase glasses, contact lenses, or other supplies from our offices, please understand that the products/supplies are non refundable. **All materials are to be paid in full prior to ordering.** If there is a balance due for any other service or material purchase from a previous date, it **must be paid** prior to ordering new product. We will be happy to adjust your glasses, replace nose pads, and screws at no charge. A shipping charge of \$10 is required when ordering product including warranty replacements. Some exclusion may apply.
3. _____. If you have no health insurance, payment is expected in full at the time of service
4. _____. There will be a \$35 service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office of your returned check, payment of the entire balance is due immediately. We will accept payment in the form of Credit card, cash or money order. Should you fail to reply within 7 days, our office will forward the balance to Telecheck for collections. There may be additional fees from Telecheck as well.
5. _____. We are Medicare participating providers; therefore, we will bill Medicare directly. However, as with any insurance carrier, you will be responsible at the time of services for payment of:

- **The annual deductibles**
- **Co-payments**
- **Charges for non-covered services**

You will also be asked to sign an Advanced Beneficiary Notice (ABN) form in the event a service is provided, which we know is not covered by Medicare.

For your convenience we accept cash, pre-printed NON temporary checks, Visa, MasterCard, American Express, Care Credit and Discover. If you have any questions please do not hesitate to ask us. We are here to assist you in any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Signature (If minor, parent must sign)

Date